DOCUMENT RESUME

ED 269 702 CG 019 089

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TITLE Group Treatment of Post-Traumatic Stress Disorder in Older Veterans.
PUB DATE Aug 85
NOTE 29p.; Paper presented at the Annual Convention of the American Psychological Association (93rd, Los Angeles, CA, August 23-27, 1985).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Emotional Disturbances; *Group Therapy; Males; *Older Adults; *Stress Management; Stress Variables; *Veterans
IDENTIFIERS *Posttraumatic Stress Disorder

ABSTRACT

Delayed and chronic symptoms of Posttraumatic Stress Disorder (PTSD) have been documented in Vietnam veterans for up to 10-15 years following the stressor and in veterans of World War II and Korea for as long as 40 years. Group therapy for Vietnam veterans with PTSD has been found to be an effective treatment, but prior research has not tested whether this model is applicable to those with more long-lasting reactions. To examine this issue, approximately 60 elderly veterans who were referred from various sites in the Palo Alto, California, Veterans Administration Medical Center were screened. Subjects (N=27) diagnosed as having PTSD were accepted into one of three therapy groups. Each group held approximately 20 sessions and developed a similar progression in which the men gradually became able to share painful memories and emotions, and then to integrate these experiences into their lives. Objective follow-up measures of PTSD symptoms (Impact of Event Scale and Post-traumatic Stress Scale) conducted prior to treatment, at the completion of treatment, and again 1-2 years later showed that those who completed treatment exhibited a decrease in their levels of symptomatology, while those who dropped out of treatment showed no change. However, the number of group members who completed treatment and were available for follow-up was small (N=7), as was the number of non-completers (N=7), and this data did not reach statistical significance. Further research is indicated in the area of long-term stress reactions, and the utility of group treatment for those with chronic PTSD. (Author/NB)

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GROUP TREATMENT OF POST-TRAUMATIC STRESS DISORDER IN OLDER VETERANS

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Presented at the 93rd Annual Convention of the American Psychological Association at Los Angeles, California, August, 1985.

Abstract

Delayed and chronic symptoms of Post-traumatic Stress Disorder (PTSD) have been documented in Vietnam veterans for up to 10-15 years following the stressor. However, the authors have found evidence of PTSD in veterans of World War II and Korea which has persisted for as much as 40 years. Since the presence of such long-term stress reactions is just beginning to be documented, very little information is available about treatment for those with chronic PTSD. Group therapy for Vietnam veterans with PTSD has been found effective, but prior research has not tested whether this model is applicable to those with long-lasting reactions.

In an attempt to better understand the nature of chronic PTSD and to discover the utility of group therapy for these older veterans, the authors screened approximately 60 elder veterans who were referred from various sites in the Palo Alto V.A. Medical Center. From these, 27 were diagnosed as having PTSD according to DSM-III criteria and were accepted into group therapy. These men showed significant general physical and emotional distress, as shown by their reported elevations on all scales of the Symptom Check List (SCL-90-R).

A total of three groups were conducted, lasting approximately 20 sessions each. Each group developed a similar progression in which the men gradually became able to share painful memories and

emotions, and then to integrate these experiences into their lives. The men were enthusiastic about their treatment, and many requested extensions of the groups.

Objective follow-up measures of PTSD symptoms (Impact of Event Scale and Post-traumatic Stress Scale) conducted prior to treatment, at the completion of treatment and again 1-2 years later showed changes in the predicted direction. Those who completed treatment showed a decrease in their levels of symptomatology, while those who dropped out of treatment showed no change. However, the number of group members who completed treatment and were available for follow-up was small (n=7), as was the number of non-completers (n=7), and this data did not reach statistical significance. Further research is indicated to continue to evaluate the presence and nature of long-term stress reactions, and the utility of group treatment for those with chronic PTSD.

Group Treatment of Post-traumatic Stress Disorder In Older Veterans

Psychological stress reactions resulting from combat exposure have been documented for many years. Various early theories appeared in an attempt to account for the appearance of symptoms such as anxiety, phobias, irritability, insomnia, nightmares and exaggerated startle responses related to war exposure.

Prior to World War I, psychological casualties of combat were thought to be defects of courage or morality. Then the concept of "shell shock" was introduced during World War I, suggesting that nonspecific neurological damage resulting from repeated exposure to the air blasts of high explosives created these symptoms (Figley, 1978). Years later, World War II and the growing influence of psychoanalytic theory produced the diagnosis of "war neurosis," emphasizing a predisposing personality conflict exacerbated by the traumatic experience of combat (Goodwin, 1980).

Concurrent with these developing theories came a variety of treatment techniques, ranging from hypnosis to disciplinary action to intensive psychotherapy intended to uncover basic personality conflicts (Figley, 1978; Glass, 1954). The relative lack of success of these treatment methods led to the adoption of brief interventions near the combat area and early reintegration into the combat unit. This strategy of on-site therapy, combined with

limited tours of duty resulted in decreasing evacuation for psychaitric reasons, from 23 percent in World War II, to six percent in Korea, to one percent in Vietnam (Bourne, 1970).

In spite of this apparent success in treating war stress, another phenomenon began to emerge. Men with continuing or delayed symptomatic reactions similar to those seen immediately after World War II were noted at periods of five years (Futterman & Pumpian-Mindlin, 1951), 15 years (Archibald, Long, Miller & Tuddenham; 1962; Dobbs & Wilson, 1960), and 20 years (Archibald & Tuddenham, 1965). Similar chronic and delayed reactions have been noted in survivors of concentration camps (Chodoff, 1963; Klein, Zellermayer & Shanan, 1963).

However, general acceptance of the concept of a post-traumatic stress reaction did not develop until the 1970's when many Vietnam veterans began to suffer alientation, insomnia, nightmares, difficulty concentrating, depression and other symptoms in the period nine to 60 months after demobilization (Shatan, 1978). By this time, evidence was emerging which directly linked length and severity of exposure to subsequent stress reactions (Klonoff, McDougall, Clark, Kramer & Hogan, 1976). Thus, only in recent years has the diagnosis of Post-traumatic Stress Disorder gained serious recognition, which is likely due to the sheer numbers of Vietnam veterans experiencing these symptoms. This recognition, most notably seen

in the inclusion of Post-traumatic Stress Disorder in DSM-III (American Psycxhiatric Association, 1980), also marks a theoretical shift away from an emphasis on predispositional factors and toward an assumption that extreme stressors evoke significant symptoms of distress in most people.

Numerous forms of therapy have been utilized with veterans experiencing this disorder, with individual psychotherapy the treatment of choice for many years. More recently, new treatments have yielded various degrees of success: systematic desensitization (Kipper, 1977; Schindler, 1980), flooding (Black & Keane, 1982; Fairbank & Keane, 1982; Fairbank, Gross & Keane, 1983); family therapy and support groups for spouses (Figley & Sprenkle, 1978; Stanton & Figley, 1978; C. C. Williams, 1980); abreaction with drugs or hypnosis (Zarcone, Scott, & Kauver, 1977; Brende & Benedict, 1980; Spiegel, 1981); medications (Friedman, 1981; Hogben & Cornfield, 1981); and individual psychotherapy (Horowitz, 1974) have shown positive results with Vietnam veterans. Current research and clinical experience, however, suggest that group therapy may be the most effacacious as well as the treatment preferred by these young veterans (T. Williams, 1980; Lifton, 1873, 1978). The group process appears to provide a unique experience involving a predictable progression in an atmosphere of support and community.

While much attention has focused on the diagnosis and treatment of delayed stress reactions in Vietnam veterans, little data exists regarding the Veterans of World War II amd Korea. Indeed, the phenomenon of a protracted stress reaction as late as 40 years following war experience is just beginning to be documented (Christenson, Walker, Ross, & Maltbie, 1981; Holmstrom, Waid, & Sexhauer, 1984). The authors' recent work with three groups of World War II and Korean veterans supports this developing evidence that chronic and delayed stress symptoms can persist as much as 40 years, and goes further to begin to assess the utility of treatment for these long-term reactions.

The Group Therapy Program

The impetus for developing a treatment program came from several independent events in which patients, families, and their therapists requested assistance in managing flashbacks, nightmares, anxiety and other problems associated with combat experiences and the delayed stress phenomenon. A group therapy model emphasizing discussion of experiences and expression of associated affect was developed based upon the programs implemented for Vietnam veterans. Goals centered on providing a therapeutic experience for these men as well as further studying this phenomenon ahd the potential efficacy of group treatment.

Over a period of three years, approximately 60 veterans were screened from referrals received within the Palo Alto V.A. Medical Center. Twenty-seven of these men were diagnosed as Post-traumatic Stress Disorder (PTSD) according to DSM-III criteria (see Table 1) and were accepted for group treatment. Ranging in age from 53 to 70, nearly all had experienced heavy prolonged combat, and 10 had been prisoners of war. Twenty-three were receiving service-connected pensions, primarily for physical disabilities. The majority of the men acknowledged using alcohol to excess at some point, often to avoid painful feelings and intrusive memories of war. Compulsive work had also been utilized as a common avoidant coping mechanism. Most reported some difficulty with impulse control, and at least four had been jailed or hospitalized because of actual or threatened violence since their discharge from the military. Sixteen had some prior psychiatric treatment or counseling, and 26 had current physical ailments in addition to their psychological distress. Financial problems, difficulties in family relationships, concerns about adjusting to retirement and tendencies toward isolation were also typical of this group. In general, those reporting less distress were most likely to drop out of treatment.

While some members had sought treatment at an earlier time for their nightmares, intrusive memories and flashbacks, most had not. Referrals came primarily from wards and clinics handling

medical and psychological problems, where veterans had requested treatment for ulcers, anxiety, depression and other stress-related disorders. Only one individual had sought treatment specificaly for PTSD symptoms.

The Group Process

Each group made an initial contract of weekly sessions for four months. Initial meetings found some veterans displaying remarkably intense anger and resentment. They voiced rage toward the U.S. Government and others for a perceived nonresponsiveness to their distress and unwillingness to compensate them for all they had endured. Others initially seemed timid and withdrawn, and hesitated to speak.

The following stage involved "war stories" from some of the more verbal members, recounting their experiences in a reportorial style. Gradually, the quieter members began to share some of their own memories, often with obvious difficulty. Soon, the recollections began to include an intense re-experiencing of affect. Many reported an increase in their symptoms during this phase. The men began to develop a strong cohesiveness and referred to the groups as a place where they had been heard and understood as never before. Those experiencess in which they felt helpless in the face of uncertainty and death were both most

difficult to share and most relevant to their nightmares and flashbacks.

The last phase of the group involved an integration of the past and present, addressing current concerns and family stress, such as the last children leaving home; increasing physical illness; sexual difficulties; retirement; financial problems; changes due to aging; and approaching death. These current stressors appeared to exacerbate long suppressed memories of losses, helplessness and disabilty during combat or captivity. Thus, it seemed important that the men deal with both past and present aspects of their lives.

At the completion of four months of weekly sessions, two of the groups chose to meet for an extended period and continued discussing generally current issues, although some content of combat continued to emerge.

The men tended to report an increase in symptoms in the initial group sessions. However, these symptoms were described as becoming less frequent or less disturbing as the groups progressed. Several men commented that they felt more relaxed and their family relationships had improved. They were generally enthusiastic about the treatment groups and reported an improved sense of well-being for having participated in the therapeutic experience. This was conveyed most clearly in their requests that the groups continue beyond the scheduled termination date.

Method

The 27 veterans who were accepted for the three courses of group treatment completed the SCL-90-R (Derogatis, 1977), a symptom checklist measuring general physical and emotional distress. Those in the later two groups also completed the Impact of Event Scale (see Table 2) and the PTSD Scale (see Table 3), instruments developed specifically to measure symptoms of PTSD. At the end of group treatment, and again at a 1-2 year follow-up, the men completed the same scales administered prior to treatment. Follow-up data included those who had dropped out of treatment (n=7), as well as those who finished treatment (n=9).

A one-way repeated measures analysis of variance, looking at the total scores across time, was conducted on the pre-, post-, and follow-up scores. In additon, a T-test was used to test for significance between scores for completers and non-completers.

Results

Initial and final SCL-90-R data (see Tables 4 and 5) revealed substantial distress. Elevations were present on all scales. Frequently endorsed items included "Worrying too much about things," "Feeling easily annoyed or irritated," "Feeling tense or keyed up," "Repeated thoughts that won't leave your mind" and "Feeling low in energy or slowed down." This pattern is similar to that noted by Horowitz, et.al.(1980) who found multiple

SCL-90 scale elevations in a study of individuals experiencing PTSD from a recent personal injury or death of a family member. The SCL-90-R data for this group did not show tendencies toward change in the pre- and post-treatment measures.

The results of the Imapct of Event Scale and the PTSD Scale showed indications of change in the predicted directions. Those who completed treatment reported less symptomatology at the end of group therapy, a process of decreasing symptoms which continued for the following 1-2 years until the time of follow-up. Those who dropped out of treatment showed essentially no change over this same period. While the decrease in symptoms followed our hypothesis that group treatment would be more effective than an absence of treatment in decreasing symptoms of chronic PTSD, the number of men who were in the latter two groups which completed the PTSD assessment measures and were available for follow-up was small (completers: n=7; non-completers: n=7) and these changes did not reach statistical significance (see Tables 6 & 7).

Discussion

Chronic PTSD reactions have been considered resistant to change (Grinker & Spiegel, 1963) and this impression is supported by the evidence that these older veterans did not show the dramatic improvement in symptomatology sometimes seen in Vietnam veterans during the course of treatment. However, indications

from this study suggest that group treatment may have some beneficial effects for those suffering from chronic PTSD.

The men participating in these groups reported enthusiasm and satisfaction about their treatment experience. Interestingly, many of their positive comments had little to do with an actual decrease in symptoms. Finding the reassurance that they were "not losing their minds" amd that they "could talk about these things with others who understood" seemed to enhance the veterans' sense of coping ability. Also mentioned were the satisfactions from social contacts and time-structuring during periods when many experienced exacerbated life stress. Thus the utility of group therapy for the elder veteran with PTSD seems to encompass social and personal gains which may be more useful than the actual decrease in symptoms.

While this work provides only preliminary data about the efficacy of group treatment, it does show evidence of PTSD as late as 40 years following the stressor. Retirement, family conflict. loss, physical illness and aging appeared to be related to a re-emergence of stress symptomatology in this group of veterans. This observation leads to speculation about the typical course of stress disorders and the implications for younger individuals who have experienced trauma. Perhaps Vietnam veterans, victims of assualts and fires, or persons experiencing other ordeals can expect a re-activation of nightmares, anxiety, sleep disturbance

and other symptoms during times of transition or loss later in their lives.

Future research is indicated to better determine the extent and nature of chronic PTSD, the typical course, and the utility of group therapy or other methods of treatment for elders with these long-term stress reactions.

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Table 1

Diagnostic Criteria for Post-traumatic Stress Disorder

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Reexperiencing of the trauma as evidenced by at least one of the following:

1. recurrent and intrusive recollections of the event
2. recurrent dreams of the event
3. sudden acting or feeling as if the traumatic event were reoccurring, because of an association with an environmental or ideational stimulus

C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following:

1. markedly diminished interest in one or more significant activities
2. feeling of detachment or estrangement from others
3. constricted affect

D. At least two of the following symptoms that were not present before the trauma:

1. hyperalertness or exaggerated startle response
2. sleep disturbance
3. guilt about surviving when others have not, or about behavior required for survival
4. memory impairment or trouble concentrating
5. avoidance of activities that arouse recollection of the traumatic event
6. intensification of symptoms by exposure to events that symbolize or resemble the traumatic event

Note. From Diagnostic and statistical manual of mental disorders (p. 238) by the American Psychiatric Association, 1980, Washington, DC: Author

Table 2

Post-Traumatic Stress Scale

Name _____ Date _____

Below is a list of problems that often occur in the months or years following a stressful experience such as wartime combat or experiences in a prison camp. We would like to know how much each of these is troubling or distressing you now.

	Does not trouble me at all	Somewhat Troubling	Troubles me a Great Deal
1. Recurrent painful or unwanted memories of your POW or war experiences.	_____	_____	_____
2. Painful dreams or nightmares about the stressful experience.	_____	_____	_____
3. Feeling that the stressful experiences actually happening again.	_____	_____	_____
4. Inability to feel strong emotions - especially those associated with intimacy and tenderness.	_____	_____	_____
5. Excessive alertness or excessive reactions to unexpected noises.	_____	_____	_____
6. Guilt about surviving when others did not or guilt about the things you had to do in order to survive.	_____	_____	_____
7. Avoiding activities or situations that might remind you of the stressful events.	_____	_____	_____
8. Events or situations that resemble or remind you of the traumatic experiences causing an increase in the kinds of problems listed above.	_____	_____	_____

9. How often since the war have you found yourself seriously troubled by these problems?

_____ Never
_____ Always
_____ Sometimes
_____ During limited periods

Note. Developed by the authors: H. R. Dickman, R. A. Zeiss.

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Table 3

IMPACT OF EVENT SCALE

During your military service you experienced one or more violent life-threatening events. Below is a list of comments made by people after stress events. Please check each item, indicating how frequently these comments were true for you DURING THE PAST SEVEN DAYS. If they did not occur during that time, please mark the "not at all" column.

Name_____

Date_____

	FREQUENCY			
	Not at all	Rarely	Sometimes	Often
1. I thought about it when I didn't mean to.				
2. I avoided letting myself get upset when I thought about it or was reminded of it.				
3. I tried to remove it from memory.				
4. I had trouble falling asleep or staying asleep.				
5. I had waves of strong feelings about it.				
6. I had dreams about it.				
7. I stayed away from reminders of it.				
8. I felt as if it hadn't happened or it wasn't real.				
9. I tried not to talk about it.				
10. Pictures about it popped into my mind.				
11. Other things kept making me think about it.				
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.				
13. I tried not to think about it.				
14. Any reminder brought back feelings about it.				
15. My feelings about it were kind of numb.				

From: Horowitz, M. J. & Wilner, N. (1980). Life events, stress and coping. In L. W. Poon (Ed.), Aging in the 1980s (pp. 363 - 374). Washington, DC: American

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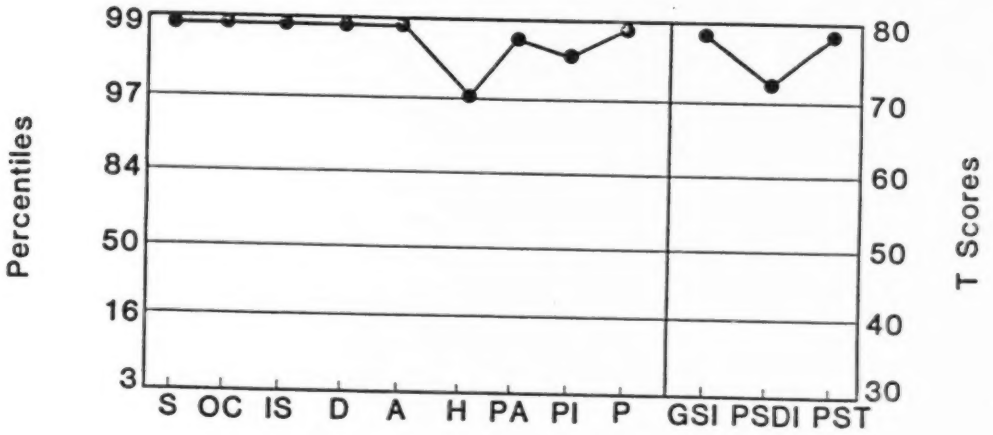
Table 4

SCL-90
Self-Reported Subjective Distress
Compared to Normal Males (n 26)



The SCL-90-R is a 90-item self-report symptom inventory.

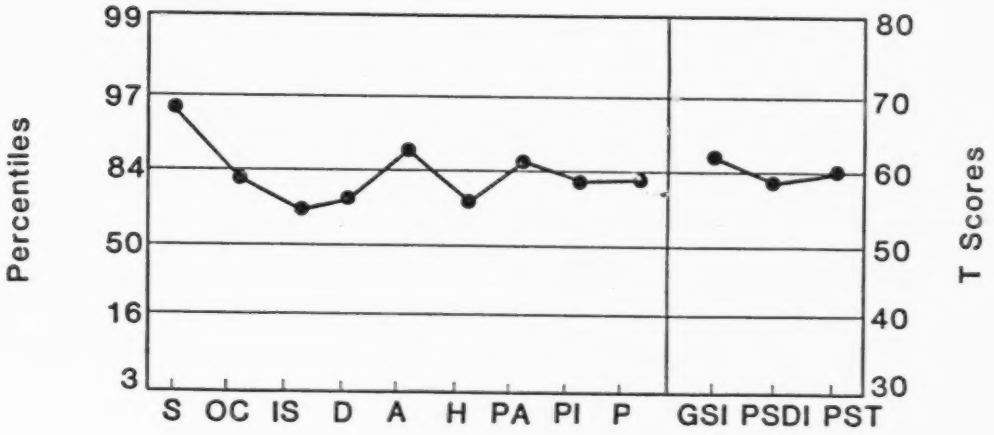
Somatization: distress from perceptions of bodily dysfunctions
Obsessive-Compulsive: worried, indecisive, rumimative
Interpersonal Sensitivity: feelings of personal inadequacy, particularly in comparison with others
Depression: dysphoric mood and affect, cognitive and somatic correlates of depression
Anxiety: nervous, apprehensive, fearful
Hostility: aggressive, irritable, resentful
Phobic Anxiety: irrational fears
Paranoid Ideation: externalization, suspiciousness, grandiosity
Psychoticism: interpersonal alienation, psychotic symptoms

Global Severity Index: overall level of distress
Positive Symptoms Distress Index: the intensity of symptoms
Positive Symptom Total: number of symptoms reported positive

Note. From Derogatis, L. R. (1977). SCL-90-R Manual. Baltimore, Maryland: Leonard R. Derogatis, Ph.D.

Table 5

SCL-90
Self-Reported Subjective Distress
Compared to Male Psychiatric Outpatients (n 26)



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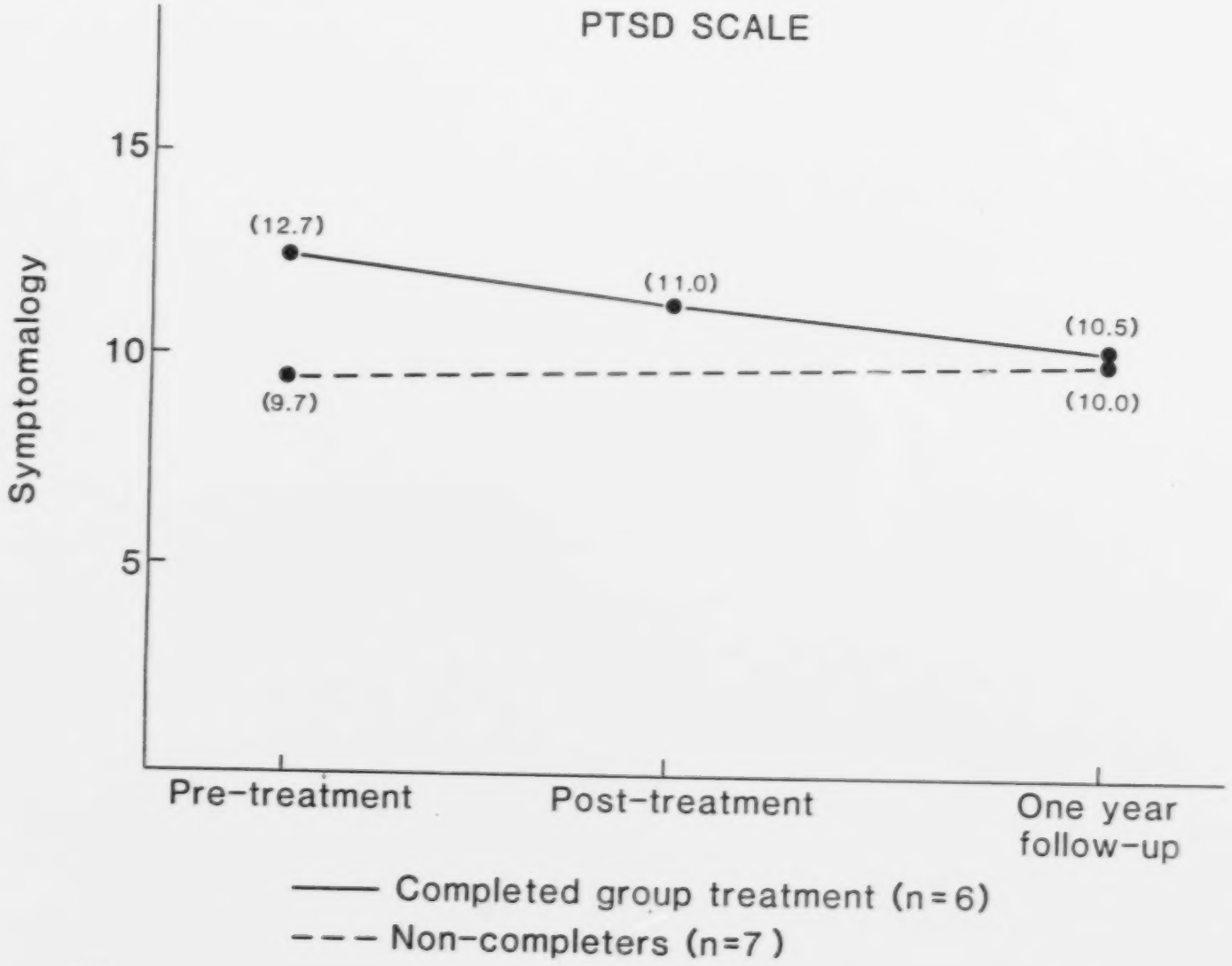

Table 6

PTSD Group 25

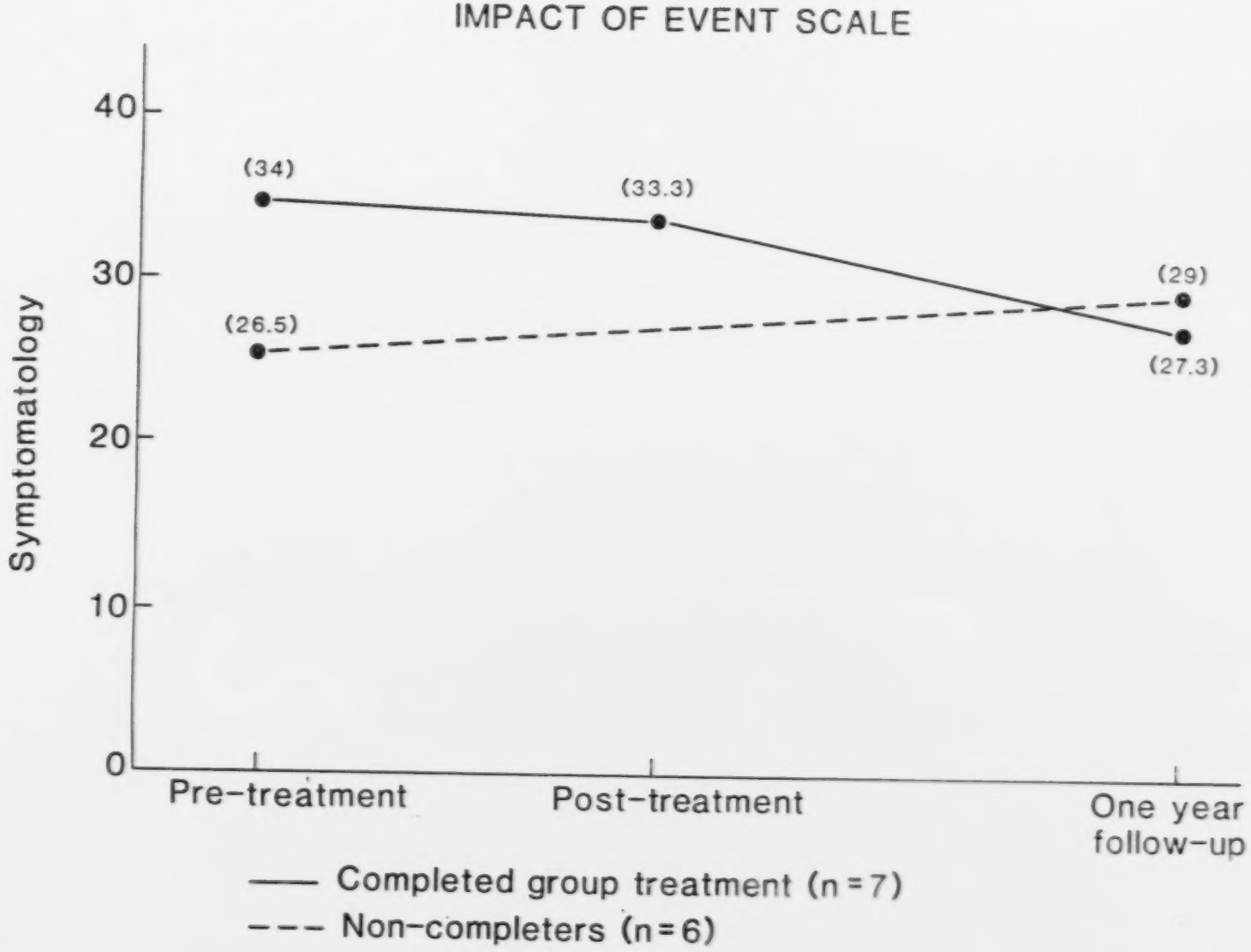

Table 7

PTSD Group 26